DEPARTMENT OF BENEFIT PAYMENTS
744 P Street, Sacramento, CA 95814

July 14, 1975

ALL-COUNTY LETTER NO. 75-142

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: Other Health Insurance Survey

REFERENCE:

On approximately July 18 of this year the Office of Operations Review of the Department of Benefit Payments will be mailing a questionnaire to a random sample of approximately 1,000 persons whose names appeared on the June C.I.D. file. This will be the first phase of a survey to determine the error rate in the reporting of "other health insurance" by Medi-Cal recipients.

A copy of the questionnaire is attached for your information. If individuals who have been selected to participate in the survey contact you, please have them call our office collect on (916) 322-6425. Should you have any questions, please contact Loren D. Suter at the same number.

JERRY W. GREEN
Assistant Director
Office of Operations Review

Attachment

cc: CWDA

GEN 654 (2/75)

OBSOLETE
Superseded by ACL # 77-15
Issued 3-17-77

DEPARTMENT OF BENEFIT PAYMENTS

July 18, 1975

The Department of Benefit Payments is conducting a survey to determine whether or not persons receiving Medi-Cal benefits have any other health insurance coverage in addition to Medi-Cal. Other health insurance means hospital, emergency room, surgery, doctor, medication, and other medically-related coverage for which you, an employer, union, or other group is paying.

You have been selected, at random, from Medi-Cal program records for participation in this survey. We are requesting that you (or a parent or guardian of a minor) complete this questionnaire. Please answer the following questions, sign in the appropriate space and return this questionnaire to us in the enclosed postage-paid envelope. Do not send your insurance policies, Medi-Cal identification cards, receipts, or any other supporting documents.

QUESTION	ANSWER
1. Are you now covered by Medi-Cal?	Yes ☐ No ☐
2. Do you now have other health insurance?	Yes ☐ No ☐
3. In the past have you had any other health insurance while you were also covered by Medi-Cal?	Yes ☐ No ☐
4. Is or was the health insurance provided by you or a family member?	Yes ☐ No ☐
5. Is or was the health insurance provided under a union, employer, or other group plan?	Yes ☐ No ☐
6. Where can you be contacted by telephone?	Home Area Code _____ Number _____ Work Area Code _____ Number _____

Signature_____ Date _____

Since the accuracy of our survey depends on the completion and return of all questionnaires, please complete and return this form to us even though you may have previously furnished this information. If you should have any questions regarding this questionnaire, call us collect at (916) 322-6425. Please do not call your county welfare department.

Thank you for your cooperation.

Loren D. Suter
Office of Operations Review

Español

Si tiene algunas preguntas tocante a este cuestionario, hablenos por cobrar al numero (916) 322-6425. Favor de no llamar al departamento de bienestar del contado.